

Justice Ruth Bader Ginsburg

***National Federation of Independent Business v. Sebelius***  
No. 11-393  
**Bench Announcement**  
**June 28, 2012**

**In the 1930's, Congress responded to the need of senior citizens for old age and survivors insurance. It did so by making Social Security a tax-based, entirely federal program. In 2010, Congress addressed the public need for affordable health care when sickness or injury occurs. Congress did so by taking a path unlike the one it took for Social Security. Instead of an entirely federal program, the Affordable Health Care Act gives States and private insurers important roles in**

ensuring medical care for those who need it. The question the Court must answer is whether the Constitution stops Congress from taking the course it did. I would answer, emphatically No.

I agree with the Chief Justice that Congress' power to tax and spend supports the so-called individual mandate or minimum coverage provision. But I would make that an auxiliary holding. As I see it, Congress' vast authority to regulate interstate commerce solidly undergirds the Affordable Health Care legislation. I

would uphold the legislation, first and foremost, on

ground.

Since 1937, the Court has deferred, as it should, to

Congress' policymaking in the economic and social

realm. Today, a majority of the Court rules that the

commerce power is not adequate to the task. That

ruling harks back to the era, ended 75 years ago, when

the Court routinely thwarted legislative efforts to

regulate the economy in the interest of those who labor

to sustain it. It is a stunning step back that should not

have staying power.

The Court's majority would compare health insurance to broccoli. If the Government can compel people to buy insurance, then there is no commodity the Government can't force people to purchase, so the argument goes. But healthcare is not like vegetables or other items one is at liberty to buy or not to buy. All of us will need healthcare, some sooner, some later, but we can't tell when, where, or how dire our need will be. A healthy 21 year old, for example, may tomorrow be the victim of an accident that leaves him or her an invalid, in need of constant and costly medical care. Further, to

get broccoli, one must pay at the counter. Not so of healthcare. The accident victim who cannot pay the steep price of medical services will nevertheless receive emergency and follow-up care, because the law and professional ethics so require, and because ours is a humane society. But people who do purchase insurance end up footing the bill. By requiring the healthy uninsured either to obtain insurance or pay a toll, Congress sought to end this free ride.

It is short sighted, moreover, to see the mandate as a decree that hale and hardy young people subsidize

care rendered to older, less healthy people. In the fullness of time, today's young and healthy will become society's old and infirm. Viewed over a lifespan, the costs and benefits even out. And as I just noted, the youth who does not want insurance today, may find that tomorrow, she desperately needs the services insurance is designed to secure.

What the mandate does, essentially, is to require people to pre-pay for medical care through insurance, instead of waiting, expecting to pay out of pocket at the point of service, when, in reality, many will lack the

**money to cover the cost. [Establishing payment terms for goods or services in or affecting interstate commerce is the kind of economic regulation that lies well within Congress' domain.]**

**The Chief Justice reasons that Congress can use its commerce power to regulate something already in existence, but cannot create that something in order to regulate it. But the interstate health-insurance and health-care markets are not Congress' creations; both existed well before the enactment of the Affordable Health Care Act.**

I have already emphasized the unique attributes of the healthcare market: the fact that all of us will be in it sooner or later and cannot predict exactly when; the huge free-rider problem caused by people who refrain from purchasing insurance, then become sick or injured and get care cost-free to them, but costly for those of us who have paid in advance. Because there is no comparable market, the slippery slope envisioned by the Court's majority (if health insurance today, then broccoli tomorrow) is far more imaginary than real. As a learned jurist once commented: "Judges and lawyers

live on the slippery slope of analogies; they are not

supposed to ski it to the bottom.”

**Yes, the insurance-purchase mandate is novel, but**

**novelty is no reason to reject it. As our economy grows**

**and changes, Congress must be competent to devise**

**legislation meeting current day social and economic**

**realities. For that very reason, the Necessary and**

**Proper Clause was included in the Constitution, to**

**ensure that the Federal Government would have the**

**capacity to provide for conditions and developments**

**the Framers knew they could scarcely foresee.**

**In enacting the Affordable Care Act, Congress' aim was to reduce the large number of U. S. residents, some 50 million in 2009, who lack health insurance. Congress was aware that the vast majority of those lack insurance are not uninsured by choice. One group of particular concern to Congress were individuals with preexisting medical conditions. Before the ACA's enactment, the insurance industry charged these individuals steep prices or flatly denied them coverage. Congress understood, however, that a simple ban on those practices would not work. Without the mandate**

**to acquire insurance, covering those with preexisting**

**conditions would trigger a death spiral in the health**

**insurance market: many people would not buy**

**insurance until they suffered sickness or injury,**

**premiums would skyrocket, more people would be**

**added to the ranks of the uninsured because they could**

**not pay the steep premiums, and, eventually, insurance**

**companies, left with a pool of high risk policyholders,**

**would exit the market. With the mandate, the job could**

**be done: access to insurance would be available and**

affordable; and uncompensated care would be hugely reduced.

**In no way was Congress' action improper. The mandate acts directly on individuals; it does not commandeer the States as intermediaries. And along with other provisions of the Act, it addresses the sort of country-wide problem that made the Commerce Clause essential. The crisis created by the many millions of U. S. residents who lack health insurance is hardly contained within state boundaries. Far from encroaching on State prerogatives, the Affordable**

**Health Care Act supplies a federal response to a need  
the States, acting separately, are incapable of meeting.**

**This Court has long recognized that the power to  
regulate interstate commerce “is an affirmative power  
commensurate with the national needs.” While the  
Court upholds the mandate, as it surely should, it also,  
regrettably, hems in Congress’ commerce power. In  
doing so, the Court invites assaults on national  
legislation irreconcilable with the Framers  
anticipation. Their understanding and expectation was  
that the Commerce Clause would empower Congress to**

act “in all Cases for the general Interests of the Union, and also in those instances in which the States are separately incompetent.”

My dissent from the Court’s retrogressive reading of the Commerce Clause is joined by Justices Breyer, Sotomayor, and Kagan.

There is a further issue: Congress’ expansion of Medicaid to include a larger portion of the Nation’s poor. Medicaid is the prototypical example of federal-state cooperation. Rather than authorizing a federal agency to administer a uniform national healthcare

system for the poor, as Congress did in establishing

Medicare for seniors, Congress offered States the

opportunity to tailor Medicaid grants to their

particular needs, so long as they remain within bounds

set by federal law. Congress reserved the “right to

alter, amend, or repeal” any provision of the Medicaid

Act; and participating States, for their part, agreed to

amend their Medicaid plans consistent with alterations

in the federal law. From 1965 until 2010, States

regularly conformed to amendments expanding

Medicaid, sometimes quite sizably.

**The 2010 expansion is different in kind, the Court concludes, 7 to 2. Justice Sotomayor and I disagree.**

**According to the Chief Justice, the expansion was misnamed. It did not expand Medicaid as it existed in 2010, he maintains. Instead, Congress established a wholly new program alongside “old Medicaid,” and coerced the States to accept “new Medicaid” by threatening them with loss of funds from the old program if they hold out. On this reasoning, the Court, for the first time ever, finds an exercise of Congress’ spending power unconstitutionally coercive.**

**In truth, however, Medicaid is a single program with but one constant aim — to enable poor persons to receive basic healthcare when they need it. What the expansion does is simply this: It adds more people, all of them poor, to the Medicaid-eligible population. Congress did not otherwise change the operation of the program.**

**The Chief Justice justifies his characterization of the expansion as a new program on three grounds. First, he says, by covering those earning up to 133% of the federal poverty line, the expansion, unlike Medicaid**

as originally enacted, does not “care for the neediest among us.” The expansion covers adults earning less than \$15,000 annually. Those low earners, on any fair assessment, rank among the Nation’s poor.

Second, the Chief observes that newly eligible people receive a level of coverage less comprehensive

than the traditional Medicaid package. But the ACA did not introduce the less comprehensive package.

Since 2006, States have been free to use it for many of their Medicaid beneficiaries.

**Third, the reimbursement rate for participating States is different. True, but that rate is markedly more generous than the usual federal contribution, hardly something the States can complain about. The Federal Government picks up 100% of the tab initially, gradually reducing to 90%.**

**Suppose Congress had from the start made Medicaid-eligible all those originally covered, plus those added by the expansion. That would be unobjectionable under the Chief Justice's reasoning. But we have never held that a grant program becomes**

**two rather than one when Congress lays a foundation and later builds on it. Congress can, and often does, expand programs, adding new conditions that grant recipients must meet in order to continue receiving funds.**

**Our decisions, I acknowledge, have hypothesized that a financial inducement might “pass the point where pressure becomes coercion,” and therefore exceed Congress’ spending power. But until today, that prospect has remained theoretical. The Court had found no case fitting the bill.**

Recall that Congress reserved to itself when it adopted Medicaid in 1965, the right to alter, amend, even repeal any provision. This Court long ago explained what those words mean. They mean Congress retains “full and complete power to make such alterations and amendments . . . as come within the just scope of the legislative power.”

States have not missed that meaning. Each time a State notified the Federal Government of a change it made in its own Medicaid plan, it certified both that it knew the federally set terms of participation could

change, and that it would abide by the changes as a

condition of continued participation.

Today's decision holds that Congress can alter a

spending program "somewhat, but not too much." We

can anticipate bolder challenges than in the past urging

that a congressional amendment goes too far, turning

"pressure . . . into compulsion." When those challenges

arrive, my colleagues may comprehend the wisdom of

the observation that conceptions of "impermissible

coercion" premised on a State's perceived inability to

decline federal funds “are just too amorphous to be judicially administerable.”

At bottom, my colleagues’ position is that the States’ reliance on federal funds limits Congress’ authority to alter its spending programs. This gets things backwards. Congress, not the States, is tasked by the Constitution with spending federal money in service of the general welfare. And each successive Congress is empowered to appropriate funds as it sees fit. When the 111<sup>th</sup> Congress reached a conclusion about the portion of the Nation’s poor that should

qualify for Medicaid, a portion larger than a predecessor Congress covered, the later Congress abridged no State's right to "existing" or "preexisting" funds. For, in truth, there are no such funds. There is only money States *anticipate* receiving, but can scarcely insist on receiving, from future Congresses.

Seven members of the Court, however, buy the argument that prospective withholding of anticipated funds exceeds Congress' spending power. Given that holding, I entirely agree with the Chief Justice as to the appropriate remedy: It is to bar the withholding found

**impermissible, not to scrap the expansion altogether.**

**This Court has many times explained that when it**

**confronts a statute marred by a constitutional**

**infirmity, its endeavor must be to salvage, not demolish,**

**the legislation. The Court does that by declaring the**

**statute invalid “to the extent that it reaches too far, but**

**otherwise [leaving the statute] intact.” Because the**

**Court finds the withholding — not the granting — of**

**federal funds incompatible with the Spending Clause,**

**Congress’ extension of Medicaid remains available to**

**any State affirming its willingness to accept the**

**uncommonly generous federal grant.**

**So, in the end, the Affordable Health Care Act**

**survives largely unscathed. But the Court's Commerce**

**and Spending Clause jurisprudence has been set awry.**

**My expectation is that the set backs will be temporary**

**blips, not permanent obstructions.**